

SCHEICH FAMILY DENTISTRY
JEFF SCHEICH, DDS **STEPHANIE SCHEICH, DDS**
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WELCOME TO OUR PRACTICE AND THANK YOU FOR TRUSTING US WITH YOUR DENTAL NEEDS!

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last First Initial

Address _____ City _____ State _____ Zip _____

Home Phone _____ Other Phone _____ Email address _____

Sex M F Age _____ Birthdate _____ Single Married Divorced Widowed

Employer _____ Occupation _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

FAMILY INFORMATION

Please list the names and birthdates of your immediate family members

Name _____ Birthdate _____

Name _____ Birthdate _____

Name _____ Birthdate _____

Name _____ Birthdate _____

INSURANCE INFORMATION

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____

Insurance Company _____

Phone # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Is patient covered by additional dental insurance? Yes No

If yes, what is the subscriber's name? _____ Soc. Sec. # _____

Insurance Company _____

Phone # _____ Group # _____ Subscriber # _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Previous Dentist _____ Date of last dental x-rays _____

Address _____

Check (✓) if you have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose or broken fillings | <input type="checkbox"/> Sensitivity to sweet |
| <input type="checkbox"/> Clicking or popping in jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you brush? _____ How often do you floss? _____

Additional questions or concerns _____

(CONTINUED ON BACK)

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you been diagnosed with Osteoporosis? Yes No

Have you been treated with a bisphosphonate (Fosamax, Actonel, Reclast, etc.)? Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

If the patient is a child, what is his/her weight? _____

Check (✓) if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List any medications you are currently taking
(include over-the-counter pain reliever or allergy medication)

Pharmacy Name _____ Phone _____

ALLERGIES

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Ibuprofen/Advil | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. Stephanie Scheich or Dr. Jeff Schelch all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I have also read and understand this office's HIPAA policies and guidelines.

Date _____ Signature _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the
Name of minor/child

dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date _____ Signature _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date _____ Signature _____